IMPROVING HEALTH SYSTEM EFFICIENCY

REPUBLIC OF KOREA

Merger of statutory health insurance funds

Soonman Kwon
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CONTENTS

1 INTRODUCTION

The Republic of Korea achieved universal health coverage based on social health insurance in 1989. Before the merger of statutory health-insurance funds in 2000, health insurance in the Republic of Korea was fragmented and consisted of more than 350 quasi-public insurance funds (societies). There were three types of health insurance fund: for employees, for the self-employed, and for school and public employees. The insured were assigned to insurance funds based on workplace (for employees) or residential area (for the self-employed). Before the merger, many health insurance funds for the self-employed in rural areas experienced serious financial distress.

Gaps in fiscal status between urban and rural (or between rich and poor) insurance funds widened over the years. Furthermore, differences in the method of setting contributions and in the amount of contribution across insurance funds raised concerns about equity in contribution payment. Members of insurance societies in poor or rural areas had to contribute a greater proportion of their income, as compared to those in wealthy areas.

This study examines the merger of statutory health-insurance funds in the Republic of Korea. Based on a political- economy approach, it examines the context, main players, policy process, and impact of the policy reform. It will determine whether the merger achieved its objectives, such as improving the exercise of purchasing power of the insurer, savings in administrative costs, and improvement in equity in contribution payment.

The study will also identify key factors associated with the positive and negative impacts of the policy change. Because healthcare reform is inherently political, the role of key players associated with the merger will also be examined. The debate involving the issue of a single fund versus multiple funds has continued since the inception of health insurance in the Republic of Korea. The role of competition among stakeholders, including labour unions and civic groups, was also crucial in the reform of the merger.

The study will examine the challenges that the health-insurance system of the Republic of Korea faces even after the merger, such as the limited exercise of purchasing power by the single insurer and differential contribution-setting for employees and the self-employed. Following the merger, the health-insurance system of the Republic of Korea now has two agencies: the National Health Insurance Service (NHIS) and Health Insurance Review and Assessment (HIRA). The functional division of the single insurer into two agencies resulted from the politics of the reform process. The final section of the study will provide other countries with lessons learnt from the reform experience of the Republic of Korea.

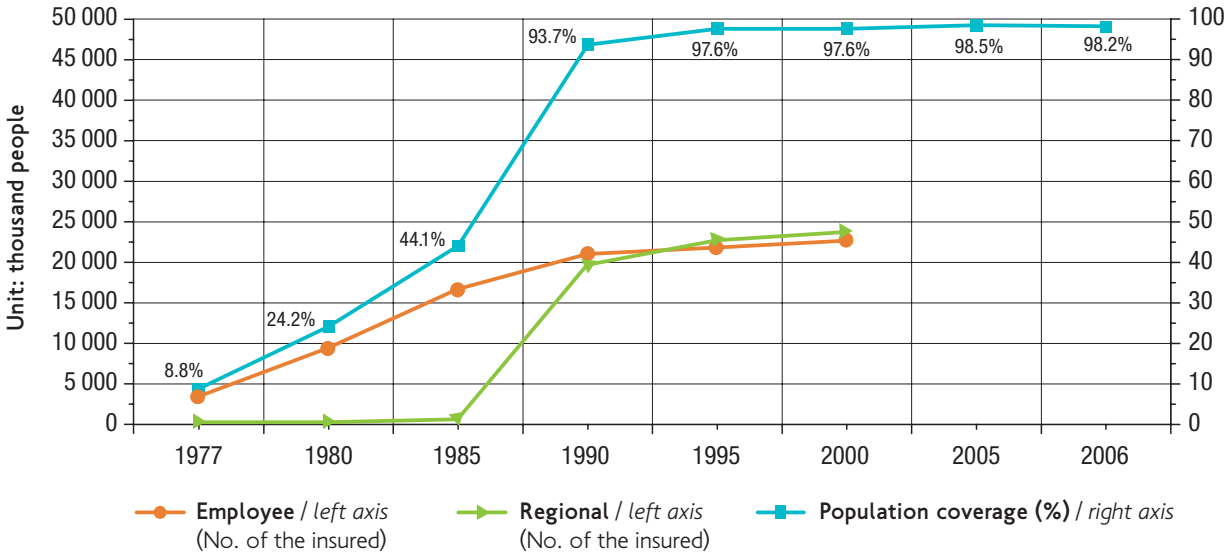
2 PATHWAYS TO THE MERGER OF STATUTORY HEALTH-INSURANCE FUNDS IN THE REPUBLIC KOREA

2.1 Historical development of the health-insurance system in the Republic of Korea

The Government of the Republic of Korea mandated health insurance first for employees, and then extended coverage to the self-employed. Employees of large businesses with more than 500 workers were the first group to be covered by health insurance in 1977; health insurance was then incrementally extended to employees of smaller corporations.

In 1988, the self-employed in rural areas joined the health-insurance system, and universal population coverage was achieved in 1989 by coverage of the self-employed in urban areas (Figure 1). Rapid economic growth in the seventies and eighties, and political legitimacy sought by the military and authoritarian regime, contributed to the rapid extension of population coverage.[1] From the beginning, health insurance in the Republic of Korea consisted of insurance funds based on employment (for employees) or residential area (for the self-employed).[2]

Figure 1. The road to universal coverage



Regional = health insurance for the self-employed.
Source: Kwon, 2009.

1 Some key economic and health indicators for the Republic of Korea are presented in the Annex.
2 See Kwon, 2009, for details.

The extension of health insurance to the self-employed elicited fierce debates concerning institutional arrangements for the universal health-insurance system. The discussions centred upon whether self-employed health insurance should adopt the then-pluralistic approach of multiple insurance funds or, alternatively, if a new single-insurer system should be created by merging with existing insurance funds for employees.

Through nationwide risk-pooling, the single-insurer system would have the potential benefit of a smooth extension of health insurance to the self-employed, with better prospects of fiscal sustainability. However, the difficulty in assessing income and collecting contributions from the self-employed was a potential barrier to a single-insurer approach. (The social consensus held that the self-employed should pay premiums based on the capacity to pay, just as employees did.)

Proponents of the merger maintained that the huge surplus of employee health-insurance funds could be used to extend insurance to the self-employed. As of 1997, the accumulated surplus of employee health-insurance funds totalled more than 113% of one year's health expenditure, while that of self-employed insurance funds was only 30% of one year's expenditure. Parliament, supported mainly by rural residents, passed the law on the merger of employees and self-employed insurance funds, but the President vetoed the law. The Government, especially the Ministry of Finance, wanted to keep the existing approach of multiple insurance funds (mainly to minimize the Government's role in healthcare financing).

2.2 Structure of the health-insurance system before the merger of statutory insurance funds

Before the merger of statutory health-insurance funds into a single insurer in July 2000 (universal coverage of the population was achieved in 1989), the national health-insurance system consisted of multiple not-for-profit insurance funds, which were subject to rather strict regulation by the Ministry of Health and Welfare (MOHW).

There was no competition among insurance funds to enrol the insured, and each fund covered a well-defined population group. Except for the review and assessment of claims submitted by providers, health-insurance funds did not actively exercise their purchasing power and there was no selective contracting with providers.

There were three different types of health insurance fund:

- health insurance for employees and their dependants (36.0% of the population);
- health insurance for school and Government employees and their dependants (10.4%); and
- health insurance for the self-employed (50.1%), which was also called regional health insurance (Table 1).

As of 1998, the Medical Aid programme for the poor, which was funded from the Government's budget, covered the remaining 3.5% of the population. In 1998, there were 227 insurance funds for the self-employed (92 in rural and 135 in urban areas), which were established in subdistricts of the city. There were 142 funds for employees and a single (nationwide) insurance fund for school and Government employees.

Table 1. Number of insured for three types of health insurance fund

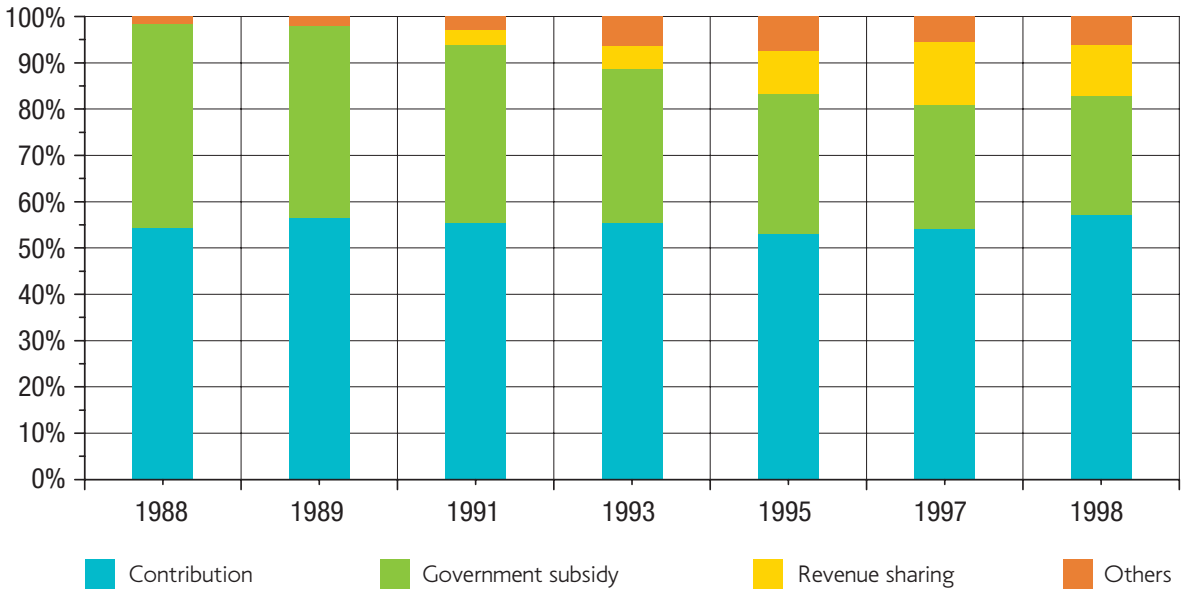
		1988	1989	1990	1995	1999	2000	2001
Total		33 196	44 168	44 110	45 429	46 821	47 466	47 882
Health insurance		28 906	39 922	40 180	44 016	45 184	45 896	46 379
Employee	Subtotal	22 129	20 982	20 759	21 559	21 717	22 404	23 167
	Insured	6 966	6 479	6 511	7 166	6 803	7 268	7 885
	Depen-dants	15 163	14 503	14 247	14 393	14 914	15 136	15 281
Self-employed	Insured	6 777	18 940	19 421	22 457	23 467	23 492	23 213
Medical Aid		4 290	4 246	3 930	1 413	1 637	1 570	1 503

Source: NHIC, Health Insurance Statistics in various years.

All insurance funds provided the same statutory benefits package to enrollees and the same reimbursement to healthcare providers. (Healthcare providers face the same financial incentives regardless of which insurance fund covers patients.) Contributions to self-employed funds were calculated based upon income, property, and household size, whereas contributions to employee funds were based only on wage income. Each insurance fund set their contribution rate within the range established by the Ministry of Health and Welfare. The Government was worried that some providers did not want to join the health-insurance programme due to tight fee scheduling. Rather than contracting with providers, the Government mandated that all medical providers treat insured patients.

The Government provided a subsidy only to insurance funds for the self-employed, intending to cover administrative expenses and part of the contributions of the lower-income group. This subsidy was provided because of the limited capacity to pay experienced by the self-employed, although the Government was not the employer for the self-employed. Over time, the Government increased the subsidy to self-employed insurance funds – although health expenditure increased at a faster rate and so the proportion of Government subsidy in the total revenue of self-employed funds has decreased ever since its introduction. In 1988, the relative share of the Government subsidy in the revenue of the insurance funds for the self-employed was 44.1%, which decreased to 25.6% in 1998 (Figure 2).

Figure 2. Source of health-insurance revenue for the self-employed



This table is from Kwon, 2003a, p.79.

Source: National Health Insurance Corporation, Health Insurance Statistics, various years.

A decrease in the role of the Government subsidy in health insurance resulted in an increase in contributions by the self-employed. As the ability to pay in rural areas was limited, many insurance funds for the self-employed suffered chronic fiscal deficits.

In response, the Government introduced a risk-sharing mechanism (designated the Fiscal Stabilization Fund) to reallocate contribution revenues across all insurance funds based on catastrophic medical expenses and population structure (that is, the proportion of elderly people) in each insurance fund.

Revenue-sharing mechanisms benefitted health-insurance funds for the self-employed (particularly in rural areas) although it failed to alleviate their financial insolvency. As of 1998, the relative share of revenue from the Fiscal Stabilization Fund in the total revenue of self-employed insurance funds was 10.9% – down from 13.6% in 1997 (NHIC, 1999). Some key characteristics (such as contributions and healthcare utilization) of the three health-insurance schemes are presented in Table 2.

Table 2. Key characteristics of three types of health insurance

		1990	1991	1992	1993	1994	1995	1996	1997	1998
Average monthly contribution per person* (100 million Won)	Self-employed	9 121	12 144	13 200	3 861	14 521	15 508	17 918	22 449	25 619
	Public and school employee	11 393	12 586	13 855	12 816	13 834	14 339	15 263	16 205	18 359
	Employed	7 598	8 790	9 949	10 884	11 840	13 165	14 831	16 253	17 374
Number of outpatient visits per person	Self-employed	2.9	3.06	3.27	3.58	3.71	4.2	4.6	4.93	4.82
	Public and school employee	3.67	3.75	3.96	4.27	4.44	4.93	5.43	5.83	6.16
	Employed	3.33	3.41	3.57	3.92	4.07	4.48	4.88	5.15	5.54
Benefit/ contribution (%)	Self-employed	103.16	75.06	82.09	89.24	93.11	107.37	114.04	105.48	104.46
	Public and school employee	84.32	72.53	78.61	92.82	95.03	105.96	126.84	132.01	146.6
	Employed	81.82	72.14	71.93	76.21	77.29	82.86	90.11	93.21	111.62

* Contribution paid by the employee, excluding the portion paid by the employer.

Source: NHIC, Health Insurance Statistics for various years.

2.3 Efficiency and equity concerns in the system of multiple insurance funds[3]

Inequity in premium contributions and the fiscal deficits of many health-insurance funds for the self-employed were the major concerns, which resulted in the merger of statutory insurance funds. Before the merger, health-insurance funds used different methods of setting contributions for employees and the self-employed. The definition of earnings for the contribution base also differed across employee insurance funds. For instance, the contribution base in some insurance funds for employees included base salary only, while others were based on total compensation. Differences in the method of setting contributions – despite identical statutory benefits packages – caused horizontal inequity across insurance funds. In other words, people with the same ability to pay contributed different premiums, depending on the insurance society in which they were (mandatorily) enrolled.

Differences in medical-care utilization existed across insurance funds – utilization was highest in school-employee and public-employee funds and lowest in self-employed funds (Table 2, above). These differences resulted from variability in the age structure – there was a larger proportion of elderly people among the dependants of school-employees and public-employees. Lower incomes among farmers and the regional maldistribution of healthcare providers also contributed to lower healthcare utilization in the self-employed funds in rural areas.

For the members of self-employed insurance funds in poor areas, the burden of their contribution as compared with their capacity to pay, was greater than for those in more prosperous regions. As a result, many self-employed insurance funds in rural areas experienced serious fiscal deficits. The aforementioned revenue-sharing mechanism among insurance funds failed to rescue rural health-insurance funds from fiscal instability, because it was largely a structural problem.

3 This section is a substantially revised version of Kwon, 2003a.

Rural areas experienced a decrease in population size, but with an increased proportion of elderly people health-insurance funds in those regions faced increasing health expenditure while their members' ability to pay remained minimal. There was a growing concern that gaps in fiscal status between urban and rural (or between rich and poor) insurance funds threatened social solidarity and fiscal sustainability of the national health-insurance system.

Before the merger, many health-insurance funds were too small in size to pool their financial risks efficiently. The absence of competition did not encourage insurance funds to merge for the purpose of improving their capacity for pooling risks. Many small insurance funds could not benefit from economy of scale in management, and proponents of the merger maintained that it would, to a great extent, save administrative costs of the health-insurance system. The proportion of administrative costs in the total expenditure was lowest (4.8%) in the single insurance fund for school and Government employees and highest (9.5%) in health-insurance funds for the self-employed (NHIC, 1999).

In the system of pluralistic insurance funds, decentralized decision-making had the potential to better meet the healthcare needs of members. However, self-governance of insurance funds was rarely realized in the Republic of Korea. The ruling political party and the Ministry of Health and Welfare often had an influence on the appointment of the chief executive officers of insurance funds. Some of them were former military personnel, persons closely affiliated with political parties, and former bureaucrats retired from government. Health-insurance funds were also subject to heavy regulation by the MOHW. The insured did not participate in the major decision-making of their insurance funds, although the strong role of the Government contributed to the rapid extension of population coverage, a uniform statutory benefits package, and a tight fee schedule for providers.

3 POLITICS AND ACTORS ASSOCIATED WITH THE MERGER OF STATUTORY HEALTH-INSURANCE FUNDS IN THE REPUBLIC OF KOREA[4]

A change in politics and a new president of the Republic of Korea opened the window of opportunity for the major policy change towards the merger (Kwon & Holliday, 2007). The new President, Kim Dae-Joong, had a progressive political ideology and a keen interest in social-welfare policy. Politicians who had their constituents in rural areas supported the merger to maximize votes from farmers enrolled in self-employed health insurance funds. Farmers, the urban poor, and the workers (officers) in self-employed health-insurance funds were strong supporters of the merger.

3.1 Government

From the beginning, the Government wanted to minimize its fiscal input into the health-insurance system. The military regime of the seventies and eighties was reluctant to mobilize fiscal resources away from the economic sector and towards social development. In addition, the Government worried that, in a single-insurer system, fiscal instability of health insurance would call for a direct Government subsidy. The Government believed that self-governance in the pluralistic health-insurance system would minimize the demand for Government involvement in financing. As a former leader of democratic movements in the Republic of Korea, President Kim Dae-Joong was very keen on social solidarity and believed that the single-insurer system was more equitable and better for social solidarity. He had included the merger of health-insurance funds in the agenda of his presidential election campaign. Members of Parliament from rural areas, regardless of their party membership, were supportive of the merger because they believed that it would solve the problem of chronic fiscal deficits in rural health-insurance funds.

3.2 Labour unions

Organized labour played a relatively minor role in the introduction and extension of health insurance in the Republic of Korea. Labour unions became active only in the late eighties, and many of them were based in large enterprises (firm-based rather than industry-wide labour unions), which were enjoying employment security and fringe benefits. However, increased unionization in small firms and huge layoffs due to the economic crisis in the late 1990s caused labour unions to pay increasing attention to social policy and safety nets (Kwon, 2001). The labour union of workers (officers) in self-employed insurance funds supported the merger, while those in employee insurance funds opposed it.[5]

Both labour unions represented to some extent the interests of the enrollees in their respective health-insurance funds. Employees were not supportive of the merger as it would increase their contributions – their income being easier to assess and the income of the self-employed believed to be underreported. Furthermore, the merger would provide a better and nationwide career path for those working in the funds for the self-employed. Before the merger, health-insurance funds for the self-employed were small and localized, with little rotation of personnel.

4 This section is a substantially revised version of Kwon, 2003a.

5 The labour union of self-employed health-insurance funds and the labour union of employee insurance funds were affiliated with different federations. The former is under the "Korean Confederation of Trade Unions" (KCTU), usually regarded as more radical; and the latter is under the "Federation of Korean Trade Unions" (FKTU).

3.3 Academics and civic groups

Progressive academics in the fields of social welfare and public health supported the single-insurer system, whereas liberal academics who favoured decentralization and market competition preferred the system of multiple insurance funds. Progressive groups viewed multiple health-insurance funds as preserving inequality of socioeconomic status and class, harming social solidarity. The progressive academics had strong coalitions with progressive civic groups, farmers' associations and the labour union of self-employed health-insurance funds. Those progressive groups developed the discussion on the organization of the health-insurance system into social movements towards social-policy reform for solidarity. As a strong ally of the new President, they became deeply involved in the policy process of the merger and other healthcare reforms.

3.4 Self-employed

The extension of health insurance to the self-employed in the late eighties faced difficult challenges. Farmers in particular refused to pay contributions and requested major reforms such as discounted contributions, change in the method of setting contributions (based only on earnings rather than on both earnings and property), increase in the Government subsidy, and the expansion of healthcare facilities in rural areas.

In the late eighties, farmers' organizations led protests and formed coalitions with other supporters of health-insurance reform. They later believed that the merger of their insurance funds with those for employees and those in rich urban areas would solve many of the problems that their insurance funds faced, including chronic fiscal deficit. Protests by farmers, which were initially motivated by the economic burden of contributions, developed into the movement towards the merger of health-insurance funds, with the support of progressive academics and civic groups.

3.5 Employers and employees

Major employers supported the system of multiple insurance funds because they expected to have an influence over the management of the accumulated surplus from firm-based insurance funds (Kim, 1989). Employees and their employers were opposed to the merger because they worried that the difficulty of income assessment of the self-employed would result in a cross-subsidy (from employees to the self-employed) and an unfair economic burden on employees.

However, due to the economic crisis, which called for the International Monetary Fund (IMF) rescue loan in the late 1990s, employers had to focus more on economic issues such as structural adjustment and employment issues. As a result, employers did not have a strong voice in the policy process – although they were a potential stumbling block in the merger process.

3.6 Medical-care providers

Medical-care providers did not actively participate in the policy process of the merger. Compared with the system of multiple insurance funds, a single insurer would have greater purchasing power, potentially threatening provider autonomy. In terms of purchasing, however, the multiple funds already had single purchasing based on uniform provider payment and benefits packages along with centralized claim review.

The merger had a potential benefit in that the single-insurer system could solve the fiscal insolvency of rural health-insurance funds. This was good news for medical providers, particularly in rural areas. Providers were more concerned about the pharmaceutical reform that separated prescribing by physicians from dispensing by pharmacists, which led to nationwide physician strikes (Kwon, 2003c).

4 MERGER OF STATUTORY HEALTH-INSURANCE FUNDS IN THE REPUBLIC OF KOREA

4.1 Merger

In order to improve the efficiency and equity of health insurance, the National Assembly passed a law to merge insurance funds into a single fund. In October 1998, the health-insurance funds for the self-employed and for school and Government employees were merged to create the National Health Insurance Corporation (NHIC). In July of 2000, employee health-insurance funds were merged (administratively) into the NHIC, and national health insurance in the Republic of Korea changed to a single-insurer system. However, the merger of financing took place two years later than the administrative merger. As a result of the merger into a nationwide single pool, the single insurer applied a nationwide contributions schedule for the insured.

4.2 Health insurance agencies

The merger not only introduced a new single insurer agency (the National Health Insurance Corporation),[6] but also created a new insurance review agency, Health Insurance Review and Assessment (HIRA). Even before the merger, claims were reviewed by a central agency, which was under the association of health-insurance funds for employees. As the association of employee insurance funds was against the merger, it suggested to the Government that the insurance system should have a separate agency for claim review and medical assessment, independent from the new single-insurer agency.

For a long time, healthcare providers complained that claim review was frequently driven by the fiscal concerns of the insurer. They requested that medical claims be reviewed on the basis of the appropriateness of services rather than the fiscal concerns of the insurance system. Consequently, healthcare providers strongly supported the idea of a separate health-insurance review agency, independent of the NHIC.

As a result, the merger created the two aforementioned insurance agencies, instead of one. Since then, the management of the health-insurance system has been divided between the two agencies based on functions. The NHIC handles premium collection, fund pooling, and reimbursement to providers; and HIRA handles purchasing such as claim review as well as the design of the benefits package and the provider payment system. From 2011, contributions to all social security programmes (health insurance, long-term care insurance, unemployment insurance, and workplace injury) are collected by the NHIC. HIRA plays an important role in determining the structure of the payment system (for example, relative values of individual services under the Resource Based Relative Value (RBRV) system of fee-for-service). However, the fee level of the fee-for-service payment system is determined by negotiation between the NHIC and each provider association, such as the “Korean Medical Association”, the “Korean Hospital Association”, and others. In the case of pharmaceuticals, HIRA determines the (positive) listing of new medicines based on economic evaluation (cost-effectiveness). The NHIC and the pharmaceutical manufacturer then negotiate on the reimbursement price of medicines.

The establishment of two separate agencies has resulted in some duplication of functions. For benefit-package decisions, technical input is provided by committees in HIRA, which may not pay enough attention

6 Its name has recently been changed to the National Health Insurance Service (NHIS).

to fiscal implications. However, there can also be some positive effects of the division of one insurance agency into two. The system of two different agencies may mitigate the potentially inefficient bureaucracy (such as lack of responsiveness) of the large single insurer organization.

The relationship between the NHIC and HIRA is heavily influenced by the Ministry of Health and Welfare. The Bureau of Health Insurance in the MOHW plays a key role in the formulation of the health-insurance policy which is implemented by the NHIC and HIRA. The authoritative monitoring power of the MOHW derives from its role in approving the budget of the insurance agencies. The MOHW also influences the appointment of the key top-level officers in the insurance agencies.

4.3 Health insurance policy-making

In the single-insurer system following the merger, major decisions on health insurance – such as contributions and benefits coverage – became a national agenda item which required a new policy framework. The emergence of the single insurer brought the previously fragmented health insurance issues into the national policy arena. After experiencing a large financial deficit in 2001 (as a result of a fee increase following pharmaceutical reform), the health-insurance system introduced the Health Insurance Policy (Deliberation) Committee, which approves major decisions on health insurance such as contribution rates, benefit packages, and pricing.

The NHIC and HIRA provide technical input and evidence to the Health Insurance Policy Committee. The Committee has 25 members, with the Vice-Minister of Health and Welfare as the chair. It is a tripartite committee of payers, providers, and experts/public agencies. Membership is designated to representative organizations. Eight members are from payers (labour unions, employer associations, civic groups, patients groups, and the like), eight from providers (associations of physicians, hospitals, dentists, pharmacists, nurses, traditional physicians, and so on), and eight representing public interests (the MOHW, the Ministry of Planning and Finance, the NHIS, HIRA, and four experts).

5 IMPACTS OF THE MERGER OF STATUTORY HEALTH-INSURANCE FUNDS IN THE REPUBLIC OF KOREA

5.1 Efficiency

The single-insurer system following the merger was expected to reduce the administrative costs of national health insurance due to economy of scale in management. Following the merger of self-employed health insurance and the Government and school employees' health insurance in 1998, 227 insurance funds of the former and 19 offices of the latter were reduced to 162 regional offices, and their manpower from 10 849 to 9073 persons as of December 1999 (NHIC, 2000).

However, there may exist an optimal size for the insurance fund, beyond which it may suffer from managerial inefficiency and a lack of responsiveness to consumer needs. If the primary objective of the merger is to reduce administrative costs, then merger into a few larger insurance funds rather than into a single one may also be an alternative. In reality, the comprehensive restructuring of the national health-insurance system faced strong resistance from the labour unions and fell short of the original goal of downsizing. There was a sharp decrease in the proportion of administrative costs in 2001 (immediately following the merger) although it had been declining since 1998 (Table 3). It is clear that the merger of statutory health-insurance funds has had a positive effect on the efficiency of the health insurance system of the Republic of Korea by reducing the share of administrative costs in total health-insurance expenditure.

Table 3. Proportion of administrative costs of the health insurance system (1996–2008)

Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2008
Total Expenditure	6 379	7 555	8 701	9 610	10 744	14 108	14 798	15 972	17 330	19 980	22 818	28 273
Administrative Costs	502	618	639	571	696	629	598	634	693	759	779	672
Proportion of Administrative Costs	7.87%	8.18%	7.34%	5.94%	6.48%	4.46%	4.04%	3.97%	4.00%	3.80%	3.41%	2.38%

Source: Health Insurance Statistics, 2012.

The single insurer would have greater bargaining power as a monopoly purchaser (a monopsony), relative to healthcare providers. However, it was not clear whether the new single insurer had the strong incentive and willingness to exercise its purchasing power. Even before the merger, the health-insurance system in the Republic of Korea had, in essence, a single/pooled purchasing system because there was no competition among funds to attract the insured, and healthcare providers were subject to a uniform payment system (regulated fee-for-service) and centralized claim review. A performance evaluation system would be important to provide an incentive for the monopolist insurer to improve its efficiency in operation.

The opponents of the merger maintained that it would result in a moral hazard for the insured as well as for workers in insurance funds (Lee, 2012). Before the merger, each insurance fund was responsible for its fiscal performance, and the insured would be keen to enhance the financial status of their own fund (for example, through a feeling of ownership). After the merger, the insured may be less concerned about the financial status of health insurance (because it is now a nationwide pool), and healthcare utilization may rise. At the

same time, collection of contributions for self-employed health insurance may be less active after the merger. However, it is extremely difficult to verify empirically if and to what extent the merger itself had an impact on healthcare utilization and expenditure.

National health insurance experienced a fiscal crisis when the accumulated surpluses were depleted in 2001. The opponents of the merger argued that moral hazard and inflexibility in raising contributions after the merger (because a nationwide contribution rate was established) contributed to the fiscal crisis. However, the annual fiscal deficit had already begun in 1997, and the sudden increase in physicians' fees by 45% after the physician strikes against pharmaceutical reform (separation of prescribing and dispensing) was the major contributing factor to the fiscal crisis (Kwon, 2007).

5.2 Equity

Only a limited amount of empirical research has examined the impact of the merger on equity in contributions. Based on data from one province, Park & Park (2001) showed that equity in health-insurance contributions improved among the self-employed after the merger. The NHIC showed that the merger increased equity in contributions to health insurance for the self-employed, thanks to a uniform nationwide contribution formula. According to the NHIC (2000), 62.2% of households nationwide experienced a decrease in monthly contributions (by 4574 Won, or US$ 4, on average) compared with the pre-merger level, and 37.8% of them experienced an increase in contributions (by 6749 Won, on average).[7]

The merger also improved equity in contributions among employees. Immediately following the merger, 56.6% of employees experienced a decrease in contributions (NHIC, 2000). Those insured who earned more than 1 540 000 Won per month experienced an increase in contributions, and the greater their income the greater the amount of the increase (Table 4). The change in the contribution also depended on the size of the employer. Workers in small firms with fewer than 10 employees enjoyed a 17% decrease in contributions, while the contribution of employees in large corporations with more than 1000 employees increased by 19.4% (Table 5).

Table 4. Effect of the new (uniform) contribution schedule upon contributions to employee health insurance (simulation results), 2000

Standardized monthly income: contribution base (10 000 Won)	Rate of change in contribution (%)	Average amount of change in monthly contribution (Won)
-52	-41.0	-7 934
52-75	-24.2	-5 588
75-100	-17.6	-5 082
100-126	-11.5	-3 999
126-154	-6.1	-2 492
154-199	3.0	1 371
199-249	9.6	5 311
249-303	15.9	10 232
303-	33.9	29 455

This table is from Kwon, 2003a, p.82.

Source: National Health Insurance Corporation, Internal Report, 2000.

7 US$ 1 is equivalent to 1000–1100 Won (of the Republic of Korea).

Table 5. Effect of the new (uniform) contribution schedule on monthly contributions to employee health insurance by firm size (simulation results), 2000

				Contribution		Change	
		Number of firms (%)	Contribution base	Old	New	Amount of change	Rate of change %
Total	170 169 (100.0)		1 467 074	40 132	40 132		
Small-sized firms	Subtotal	145 302 (85.4)					
	-10 employees	89 082	1 191 643	39 193	32 531	-6 662	-17.0
	11~30 employees	56 220	1 182 092	38 515	32 270	-6 245	-16.2
Medium-sized firms	Subtotal	23 253 (13.7)					
	31~100 employees	18 221	1 207 162	37 046	32 955	-4 091	-11.0
	101~300 employees	5032	1 291 921	36 535	35 269	-1 266	-3.5
Large firms	Subtotal	1614 (0.9)					
	301~500 employees	757	1 539 102	38 835	42 017	3 182	8.2
	501~1000 employees	482	1 650 426	41 446	45 056	3 610	8.7
	1001- employees	375	2 025 506	46 303	55 295	8 992	19.4

This table is from Kwon 2003a, p.83. Units are in Won (of the Republic of Korea).
Source: National Health Insurance Corporation, Internal Report, 2000.

The Kakwani index is frequently used to measure the progressivity of payments such as tax and health insurance contributions (O'Donnell, van Doorslaer et al., 2008). The greater the Kakwani index, the greater the progressivity of payment, that is, the rich pay more than the poor, which has a positive impact on income redistribution.

Yang, Kwon et al. (2003) show that payment of health-insurance contributions in 1996–2000 was regressive (with minus Kakwani index value), but the degree of regressivity decreased over the years. Choi (2012) shows that in 2006–2010, payment of health-insurance contributions was still regressive but less so than in the pre-merger years (Table 6).

These studies suggest that the merger has had a positive impact on equity in premum contributions although there are potentially other factors that affect progressivity. According to Choi (2012), health-insurance contributions of the self-employed are more regressive than those of employees (with the exception of 2008) – probably because it is more difficult to assess the ability to pay of the self-employed compared with employees.

Table 6. Trends in the Kakwani Index

Year		General taxes	Social insurance
1996		0.11200	-0.21660
1997		0.11530	-0.22980
1998		0.13650	-0.21210
1999		0.14410	-0.18400
2000		0.15590	-0.16340
2006	Employees	0.13846	-0.00074
	Self-employed	0.06665	-0.01741
2007	Employees	0.16250	-0.01259
	Self-employed	0.04421	-0.01845
2008	Employees	0.14840	-0.01530
	Self-employed	0.02941	-0.01483
2009	Employees	0.15387	-0.01131
	Self-employed	0.01878	-0.02219
2010	Employees	0.15986	-0.00828
	Self-employed	0.03528	-0.03373

Sources: Yang, Kwon, Lee et al., 2003 (Kakwani index from 1996–2000); Choi, 2012 (Kakwani index from 2006–2010). Both studies used household survey data from the National Statistical Office.

For equity in contribution payment, the health-insurance system should overcome the critical barrier associated with the difficulty of income assessment of the self-employed, which will also affect the tax system and other social insurance such as the national pension. Even the single insurer currently has two different contribution formulae, for employees and the self-employed. Employee contributions are based on wage income only, while self-employed contributions consider both income and assets (such as a house and automobile). In that sense, equity across employees and the self-employed may not be fully achieved after the merger.

The concept of taking into account flow (income) and stock (assets) together in the contribution formula has been controversial and caused many appeals by the self-employed. Furthermore, increasing contributions in order to expand benefit coverage and financial protection, which has been a major task for national health insurance in the Republic of Korea, would face tougher resistance unless equity in contribution improved.

But inequity in contribution also arises in the employee group, as their contribution does not take into account non-wage income. Recently, the Government has been considering the introduction of a uniform contribution schedule, based upon all types of income – although it may face some political barriers to this policy change. Income in the current contribution formula for employees considers only wage (or business) income, but not other types of income such as investment income, rental income, and so on. The current contribution schedule is inefficient (as it distorts labour participation) and inequitable (as it treats various types of income differently or allows favourable treatment of those who have high non-wage income and penalizes those who have wage-income only).

5.3 Purchasing

In the 2000s, national health-insurance benefits coverage was substantially expanded. Additional benefits included covering screening programmes for five cancers, reducing the coinsurance rate for catastrophic conditions, introducing six-month ceilings for cumulative out-of-pocket payments for covered services, and so on. Savings in the administrative expenses involved in national health insurance after the merger seemed to contribute to the fiscal space available for benefits expansion. Since the emergence of the single insurance agency, national health insurance became a major policy issue for politicians and the central Government. The Government seemed to be more responsive to the need for enhanced financial protection through expanding benefits coverage.

Merger into a single large insurance agency also contributed to the improved capacity of the NHIS agency as purchaser. In 2006, the NHIS introduced the policy of positive listing of medicines based on economic evaluation (health technology assessment). If a pharmaceutical manufacturer wants its product to be included in the benefits package, it must submit evidence of its cost-effectiveness, which is reviewed by Health Insurance Review and Assessment. Once it is decided that the product is to be included in the reimbursement list, then the NHIS negotiates the price with the manufacturer. The technical and bargaining capacity of the insurer with respect to pharmaceuticals has rapidly improved.

However, the single insurer still does not fully exercise its monopsonistic bargaining power. Health insurance pays medical providers via fee-for-service, and payment reform towards a prospective payment system has faced opposition by healthcare providers (Kwon, 2003d). In the healthcare system of the Republic of Korea, where more than 90% of hospitals are private, the threat of a strike by physicians deters the insurer from using its financial leverage as a single payer. The nationwide physician strikes against pharmaceutical reform in 2000 seem to have left a long-lasting scar on policy-makers and the insurer. The financial sustainability and the efficiency of the health-insurance system of the Republic of Korea will hinge upon its capacity and willingness to effectively use its purchasing power over providers and implement payment systems such as capitation, the DRG-based prospective payment system, and global budgeting (Kwon, 2009).

Furthermore, the Republic of Korea still has a mandate for healthcare providers to participate in the health-insurance system. However, the Republic of Korea should now reconsider the contractual relationship between the insurer and medical providers. At present, the Republic of Korea does not need to require all medical providers to join the health-insurance system, as it has a sufficient supply of providers who cannot survive without participating in the health-insurance programme (in the system of universal population coverage). To the contrary, the mandate on providers is a barrier to the exercise of monopolistic purchasing power by the single insurer, because it cannot selectively contract with providers based on their performance. Selective contracting faces opposition from the Medical Association. Civic groups are also opposed to selective contracting, concerned that some leading hospitals may not want to join the national health-insurance system.

6 LESSONS AND POLICY IMPLICATIONS

Health policy and reform cannot be simply transplanted from one country to others. Healthcare financing reform, such as the merger of insurance funds in the Republic of Korea, needs to be contextualized in terms of policy design and implementation strategy, taking into account the health-financing systems of low-income and middle-income countries. For example, health-insurance development in the Republic of Korea was Government-driven from design to implementation, which has resulted in minimum differences across insurance funds. Rapid extension of population coverage and a relatively short history have contributed to the merger, as the vested interests associated with different schemes were not yet powerful before the merger. To some extent, health insurance based on multiple funds contributed to the rapid extension of population coverage, taking into account the characteristics of different groups among the insured. However, the fragmented system faced a problem of inefficient risk-pooling and fiscal unsustainability of self-employed funds in rural areas, and the difference in fiscal capacity among funds threatened social solidarity.

In general, the single insurance system is efficient because it has a greater risk-pooling capacity and can better use its financial leverage in bargaining with providers (Kwon, 2011). It is equitable, as everybody can access the same benefits with the same contribution mechanism. However, efficiency can be achieved not necessarily by a single insurer but also by reasonably large insurers, say, those based upon regions. After a certain threshold, increasing the size of the insurance pool may have a marginal effect on the increase in risk-pooling and the bargaining capacity of the insurer.

Equity can also be achieved by uniform benefit packages, contribution setting, and a provider-payment system across insurance funds (as, for example, in Japan), although it requires a strong role of government. Therefore low-income and middle-income countries should consider their own contexts, including their government's capacity to regulate/harmonize insurance funds, in any decision to move towards a single insurance system or a system involving a few well-harmonized (regulated) insurers. The culture and history of decentralization or local autonomy also needs to be considered.

With the same benefits package and provider-payment, multiple insurance funds can function as a single purchaser. However, when tax financing is not pooled with health-insurance financing, and direct budget financing still accounts for a significant share of (public) hospital financing, then the purchasing function will be fragmented and inefficient (as in many formerly planned economies). In that case, although health insurance has a single fund, healthcare financing through public funds (tax and social health insurance) has limited purchasing power.

The single insurer system can enjoy economies of scale in management and save administrative costs. However, a large organization with a monopolistic position may involve the risk of bureaucratic inefficiency. Therefore, low-income and middle-income countries should take into account the culture of bureaucracy, and should introduce an efficient management or performance-evaluation system for the insurer organization.

Healthcare financing and reform are inherently political, involving vested interest groups. For example, enrollees in insurance funds with generous benefits coverage will oppose the merger of funds toward a single-insurer system. Political leadership, policy process, and the strategies of political actors will be crucial in the success or failure of health-financing reform. In the case of the Republic of Korea, progressive civic

groups had a coalition with the new President and positioned health-insurance reform as a social movement towards welfare expansion. Change in the policy process from an authoritarian, elite-led, top-down approach to a democratic, participatory, bottom-up approach contributed to the success of healthcare reform (Kwon & Reich, 2005). If policy change towards a single insurer system involves heavy opposition from stakeholders, the political cost of reform will be very high. Policy-makers should evaluate and compare the benefits of reform with potential political costs. Comprehensive change and incremental change (for example, merging into larger funds with the goal of a single fund in the long term) may have varying political costs.

7 CONCLUDING REMARKS

In the introduction and extension of health insurance in the Republic of Korea, the pluralistic approach of multiple insurance funds was in the interest of the Government in terms of political considerations and economic constraints. Although it was useful for incremental extension, the health-insurance system based on fragmented insurance funds was vulnerable to fiscal instability, and the differential financial capacity among funds harmed social solidarity. Fiscal instability was more likely as insurance funds were too small to have efficient risk-pooling capacity. Accordingly, a merger among insurance funds became inevitable, although whether merger should result in a single insurer or a small number of large insurers is a difficult choice.

Major driving forces behind the merger of statutory health-insurance funds in the Republic of Korea included inequity in paying for health insurance and the fiscal insolvency of many health-insurance funds for the self-employed in rural areas. The new President, with a keen interest in social-policy reform opened a policy window for healthcare-financing reform. Long-time supporters of structural change in the health-insurance system took advantage of opportunities for policy change provided in the political arena. For example, labour unions and progressive civic groups played an important role in health-insurance reform.

Compared with the system of multiple insurance funds, the single-insurer system can be more equitable and efficient in terms of administrative cost, risk-pooling, and purchasing power. As health-financing reform is political, each country should consider its own political and economic context in any discussion about institutional arrangements for health insurance (multiple funds or single insurer). Countries should also carefully design their political strategy to reach their final goal. If incremental change is considered a more viable option with less political cost, reform could begin with harmonizing benefit packages, setting contributions, and establishing provider-payment systems across insurance funds, in order to move towards single purchasing and improvement in the efficiency of the health insurance system.

ANNEX

Economic and health indicators in the Republic of Korea, 1977–2008

	1977	1989	2000	2008
GDP per capita (in USD)[a]	1 042	5 430	11 347	20 591 (2010)
Life expectancy[b]	64.8	71	76	79.9
Mortality (per 100 000 persons)[c]	690	542.3		497.3 (2009)
Infant mortality (per 1000 births)[b,c]	38	12	5.8	3.5
	(average over 1970-1975)		(average over 1999-2002)	
Number of physicians (per 10 000 persons)[b]	5 (1981)	8	13	19 (2009)
Number of beds (per 10 000 persons)[b]	17 (1981)	23	47	78
Number of physician visits per capita[b]	3.7	6.2	10.6 (2002)	13
Number of admissions per capita[c]	-0.06 (1990)	-	0.13	
Number of hospital days per admission[b,c]	12	13.6	13.8 (2002)	14.6 (2009)

Note: 1977 marked the introduction of health insurance;
1989 marked the onset of universal coverage.

Sources: a Bank of the Republic of Korea (2011); b OECD (2010); c Republic of Korea, NSO (2011).

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